TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Gregory Ennis, M.D., P.A.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-16-0069-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "EcCare Health Centers states that the amount of $150.00 is past due payable…"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is only one body part …

The Carrier is correct in reimbursing $350.00 for the MMI finding and $300.00 for the right knee impairment finding, for a total of $650.00"

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 3, 2014	Designated Doctor Examination (MMI/IR)	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Workers' compensation jurisdictional fee schedule adjustment.
   - Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.
   - The charge for the procedure exceeds the amount indicated in the fee schedule.
   - Previously paid. Payment for this claim/service may have been provided in a previous payment.

- Workers Compensation State Fee Schedule Adjustment.
- The provider has billed for the exact services on a previous bill.
- The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
- The diagnosis on the bill does not appear to be logically related to the compensable injury/disease.

Issues

1. Does a compensability issue exist for this dispute?
2. Are the insurance carrier's reasons for reduction of payment supported?
3. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services, in part, with claim adjustment reason "The diagnosis on the bill does not appear to be logically related to the compensable injury/disease." 28 Texas Administrative Code §133.307 (d)(2)(H) requires that "If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with §124.2 of this title…" Submitted documentation does not include a Plain Language Notice regarding a dispute of compensability, extent, or liability.

   Further, the insurance carrier did not maintain this denial reason on a subsequent Explanation of Bill Review, dated May 8, 2015. Therefore, the Division finds that a compensability issue does not exist for this dispute.

2. The insurance carrier denied disputed services with claim adjustment reason "Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge." 28 Texas Administrative Code §134.204 (j)(4)(A) states, "The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form."

   Review of the submitted information finds that the requestor billed for two units, indicating that two body areas received impairment ratings. The narrative indicates that the requestor provided an impairment rating for the right knee (lower extremity). The insurance carrier's reduction reason is supported. The disputed charges will be evaluated according to appropriate rules and fee guidelines.

3. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. … (C)(ii) The MAR for musculoskeletal body areas shall be as follows. … (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The submitted documentation indicates that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the lower extremity. Therefore, the correct MAR for this examination is $300.00.

4. The total MAR for the disputed services is $650.00. The insurance carrier paid $650.00. Therefore, no further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	October 2, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.